REGISTRATION FORM

Alcorn Family Resource Center
Infant & Toddler Program
_____

Seq. # _____S.S. # _____

Pupil's Name: _____ **Sex: M** ____
Last First Middle **F** ____

Address: _____ Home Phone: _____

Family Doctor: _____ Phone: _____

Verified Date of Birth: _____ Place of Birth: _____

Preschool and/or Kindergarten Experience **Yes ____NO_____** _____
Name of Preschool and/or Kindergarten

LOCAL EMERGENCY NAMES & TELEPHONE NO:
1. _____ Phone: _____

2. _____ Phone: _____

Family Data	**Name/Address**	**Place of Employment & Telephone Number**
Father		
Mother		
Step Parent or Guardian		

Name of Brothers/Sisters **Date of Birth** **Grade**
_____
_____
_____
_____
_____
_____
_____
_____

FOR OFFICE USE ONLY
_____
_____
_____
_____
_____
_____
_____

Please answer all questions:

1. What language did your child speak first?

_____

2. What is the primary language spoken by you or other persons in your home?

_____

3. What is the primary language spoken by your child when he/she is at home?

_____

Dominant language is assumed to be the language stated in at least 2 of the 3 responses to the above question

_____
Dominant Language

Physical Handicaps/Illnesses: _____
_____

1. Has your child had any illness, injury, or Operations? specify _____
_____

2. Does your child have any allergies? Please list them_____
_____

3. Does your child have **BEE STING ALLERGY**?
_____

Does your child have **FOOD/NUT ALLERGY**?
_____Specify: _____

Is child taking oral or injectable medication for above allergy? _____
Specify _____

4. Does your child take any mediation on a regular basis?
_____Specify _____

5. Are there any other health problems not already listed that the school should be aware of? _____
_____